Welcome to West Branch Veterinary Services

CLIENT INFORMATION

Owner: ____ Home Phone: _____________
(Last) (First)

Address: ____
(Mailing address) (City) (Zip)

Driver's License: ______________ (Must have if check written)

Employer: ____ Work Phone: _____________

Spouse Name: ______________________________________ Spouse Work Phone: ________

Who may we thank for referring you? ____

If you were not referred by someone, how did you first choose this clinic?

( ) Humane Society
( ) Phone Book
( ) Sign in Front
( ) Newspaper
( ) New Resident Letter
( ) Other
( ) Location

Had you heard of West Branch Veterinary Services before? Yes / No

CAN WE USE YOU OR YOUR PETS PICTURES FOR EDUCATION OR DISPLAY?____INITIAL_____

PAYMENT IS REQUIRED AT TIME OF SERVICE. FORM OF PAYMENT PREFERRED:

Cash Check Visa MasterCard

Signature:

ANIMAL INFORMATION

Pet's Name: ____ Date of Birth: ___________

Dog _______ Cat: ________ Other: _____ Sex: _______ Spayed / Neutered

Breed: _____________________ Color/Markings: __________________________________

Date of Last Vaccination(s):

Canine

Rabies ______________________________

Distemper/Hep/Parvo___________________

Bordetella____________________________

Other ________________________________

Feline

Rabies ______________________________

Distemper/Resp Virus _________________

Leukemia_____________________________

Other ________________________________

DO YOU HAVE ANY SPECIFIC QUESTIONS WE CAN ANSWER FOR YOU TODAY?

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IMPORTANT!!! PLEASE COMPLETE THE BACK OF THIS FORM!

Pet's Name: ____ Date of Birth: ___________

Dog ________ Cat: _________ Other: ______ Sex: ________ Spayed / Neutered

Breed: ______________________ Color/Markings: ____________________________________

Date of Last Vaccination(s):

Canine	**Feline**
Rabies ______________________________	Rabies ____________________________
Distemper/Hep/Parvo___________________	Distemper/Resp Virus ________________
Bordetella_____________________________	Leukemia___________________________
Other ________________________________	Other ______________________________

NEW PATIENT INFORMATION

What type of food and amount does your animal currently receive? _______________________

Is your animal currently receiving any medication? If so, what kind? _____________________

____

Does your animal have any drug allergies? If so, to what? ______________________________

____

Has your animal ever had:

( ) Fainting spells	( ) Hair loss
( ) Seizures	( ) Tumors or growths
( ) Shortness of breath	( ) Skin problems
( ) Coughing spasms	( ) Lameness
( ) Diarrhea of vomiting	( ) Dental problems
( ) Bleeding episodes	( ) Ear infections
( ) Muscular weakness	( ) Reaction to vaccination
( ) Runny eyes	( ) Other

Has your animal had care in these areas:

( ) Dental cleaning & polish	( ) Blood tests
( ) Heartworm test (dogs / cats)	( ) Fecal exam
( ) Leukemia test (cats)	( ) EKG
( ) X-rays	

Previous veterinarian(s) where past records could be obtained if necessary:

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Reason for today's visit: ____

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